U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 July 2007

CASE NO. 2006-BLA-5896

In the Matter of:

L.L.R.,
Claimant

v.

HIGH POWER ENERGY,
Employer

and

WV CWP FUND,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Otis R. Mann, Jr., Esquire
For the Claimant

William S. Mattingly, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from a claim for benefits filed by L.L.R., a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq.* Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on April 11, 2007, in Beckley, West Virginia. At that time, all parties were afforded full opportunity present evidence and argument as provided in the Act and the regulations issued. Furthermore, I advised counsel for the respective parties that the record would be held open until May 31, 2007 for the submission of post-hearing briefs (TR 26). The record consists of the hearing transcript, Director's Exhibits 1 through 28 (DX 1-28), Claimant's Exhibits 1 through 5 (CX 1-5), and Employer's Exhibits 1 through 8 (EX 1-8). I have also received and considered the closing arguments, which were filed on behalf of the Claimant and Employer, respectively.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

On July 11, 2005, Claimant filed the current application for black lung benefits under the Act (DX 2). On March 15, 2006, the District Director's office issued a Proposed Decision and Order denying benefits (DX 20). Following Claimant's timely request for a formal hearing (DX 22), this matter was referred to the Office of Administrative Law Judges for *de novo* adjudication (DX 26-28). As previously stated, a formal hearing was held on April 11, 2007, and the record was closed following my receipt of the parties' closing arguments on or about May 31, 2007.

Issues

The primary contested issues are as follows:

I. Whether the miner worked at least 10 years in or around one or more coal mines?
II. Whether the miner has pneumoconiosis as defined by the Act and the regulations?
III. Whether the miner's pneumoconiosis arose out of coal mine employment?
IV. Whether the miner is totally disabled?
V. Whether the miner's disability is due to pneumoconiosis?

(DX 26; TR 5-6).

Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on July 11, 2005 (DX 2), the new regulations are applicable (DX 28).

Findings of Fact and Conclusions of Law

I. Background

A. Coal Miner and Length of Coal Mine Employment

On the application for benefits form, Claimant stated that he worked in or around coal mines for "10 yrs." ending on September 21, 1992, when he "retired" (DX 2). Furthermore, Clamant submitted an Employment History form outlining his work history (DX 3). Among the numerous entries was a notation that Claimant worked for Geupel Construction during the years "69-71, 72-75, [and] 80-87." Furthermore, Claimant noted that from 1969 to 1971, he only did "Road Work." In contrast, during the periods from 1972-1975 and 1980-1987, Claimant stated that performed a combination of jobs in "Road Work/Strip Mines." (DX 3). At the formal hearing, Claimant alleged that he worked around coal for about 18 years (TR 16).

In contrast, the District Director's stated that Claimant established 8.58 years of coal mine employment based upon the Social Security records (DX 5). Furthermore, in the Proposed Decision and Order denying benefits, the District Director found that Claimant was employed as a coal miner for 8 years, during the period from 1975 to September 21, 1992 (DX 20). At the formal hearing, the Employer was only willing to stipulate to "at least five years" of coal mine employment, which reflected Claimant's work for the Employer ending in 1992 (TR 6).

Having carefully reviewed the record, I initially note the apparent inconsistency between Claimant's claim of 10 years of coal mine employment on the application form (DX 2), and his more recent assertion of about 18 years of such employment (DX 2; *compare* TR 16). This inconsistency may be related to neurological difficulties associated with the stroke Claimant suffered in 1992 (TR 18-19). In any event, I find that the Social Security records provide a more objective analysis of Claimant's work history.

As stated above, the District Director calculated Claimant's coal mine employment as 8.58 years based upon the Social Security records (DX 5). However, the District Director did not credit Claimant with any coal mine-related earnings for the years 1972, 1973, 1974 and/or 1980 through 1987, even though Claimant had significant earnings (DX 4), and Claimant stated that he had worked at both road work and strip mine work during those years (DX 3; *see also* TR 20). Even if only a fraction of Claimant's work during those years constituted coal mine employment, the Social Security records would establish *at least* another 1 ½ years of coal mine employment (DX 3, 4, 5). Accordingly, I find that Claimant has established *at least* 10 years of coal mine employment. Moreover, I find that any discrepancy in the exact number of years of coal mine employment (*i.e.*, between 10 and 18 years) is inconsequential, and does not effect the outcome of this decision.

B. Timeliness of Filing

Claimant filed the current claim for benefits under the Act on July 11, 2005 (DX 2). Employer has failed to present sufficient evidence to rebut the presumption of timeliness. 20 C.F.R. §725.308(c). Accordingly, I find that the claim for benefits is timely filed.[2]

C. Responsible Operator

Employer, High Power Energy, is the properly designated responsible operator in this case, under Subpart G of the Regulations (DX 2, 3, 4; TR 10).

D. Personal, Employment, and Smoking History

Claimant was born on April 16, 1938. He has one dependent for the purpose of possible augmentation of benefits under the Act; namely, his wife, Linda Kay (DX 2, 8; TR 9-10). As stated above, I find that Claimant engaged in coal mine employment for at least 10 years. Claimant testified that, except for a period in 1956 when he briefly worked in a deep mine, all of his coal mine work was spent at strip mines (TR 20-21).

Claimant's last usual coal mine job was as a "foreman" (DX 3). However, Claimant stated he was a "working foreman." Claimant testified that the job entailed chopping, cleaning the coal, taking the overburden off the coal, around the drilling and blasting. Furthermore, Claimant stated that his duties involved quite a bit of lifting on a regular basis, including items which weighed about 100 pounds, and carrying them from the pickup to the loader (TR 10-12). Claimant stopped working in 1992, after suffering a stroke (TR 10, 18-19).

Claimant stated that he suffers from shortness of breath; and, he has difficulty going up and down steps, or even walking long distances on level ground. Although Claimant sees a physician at Charleston Area Medical Center, Claimant testified that he does not take any medication or use any nebulizers for his breathing condition (TR 17).

Claimant testified that he smoked between ½ and 1 pack of cigarettes for about 15 years ending in November 1992 (TR 18). Accordingly, Claimant has acknowledged a 7 ½ to 15-pack-year smoking history. However, as discussed below, the record contains numerous conflicting smoking histories. For example, Dr. Rasmussen reported that Claimant "began to smoke when he was 7 years of age, however, he didn't smoke regularly until, he believes about 1980. He smoked about 10 cigarettes a day until he quit in 1992." (DX 10). This would suggest that Claimant had smoked "irregularly" from age 7 (*i.e.*, 1945) until 1980, but that he smoked only ½ pack per day when he smoked "regularly" from 1980 to 1992. Furthermore, Dr. Zaldivar reported that Claimant "began smoking in 1959 or 1960," and smoked ten cigarettes

[2] Claimant's testimony was, at best, ambiguous as to whether physicians ever told him that he was totally disabled due to pneumoconiosis (TR 21).

per day before quitting in 1992 (EX 2). This indicates that Claimant smoked ½ pack per day for 32 or 33 years ending in 1992. However, some of the medical records of Dr. Reahl, who was treated Claimant for the stroke, indicate that Claimant was still smoking "1 ppd" as of April 15, 2002 (EX 3, pp. 6-7; *see also* - EX 3, p. 18; *compare* – EX 3, p. 11). As fact-finder, I find that the longer, more extensive smoking histories are more credible, and that the documentary evidence, in conjunction with Claimant's testimony, establishes a significant cigarette smoking history of *at least* 15-pack years.[3]

II. Medical Evidence

The medical evidence includes various chest x-rays, pulmonary function studies, arterial blood gases, and physicians' opinions, which are summarized below.

A. Chest X-rays

The record contains nine substantive interpretations of chest x-rays, dated October 10, 2005 (DX 10; EX 1), May 10, 2006 (CX 2; EX 2), December 11, 2006 (EX 5), and, December 21, 2006 (CX 1, 4; EX 8), respectively.[4]

Of the foregoing, four interpretations are positive for pneumoconiosis under the classification requirements set forth in §718.102(b); namely, Dr. Rasmussen's (1/1) reading of the October 10, 2005 x-ray (DX 10); Dr. Pathak's (1/2) reading of the May 10, 2006 x-ray (CX 2); Dr. Gaziano's (1/1) reading of the December 21, 2006 x-ray (CX 1); and, Dr. Aycoth's (1/2) reading of the December 21, 2006 x-ray (CX 4). All of the positive interpretations were rendered by B-readers. Furthermore, Drs. Pathak and Aycoth are dual-qualified B-readers and Board-certified radiologists.

On the other hand, five of the interpretations are negative for pneumoconiosis under the classification requirements set forth in §718.102(b); namely, Dr. Wiot's reading of the October 10, 2005 x-ray (EX 1); Dr. Zaldivar's (0/1) reading of the May 10, 2006 x-ray (EX 2); Dr. Willis' (0/1) reading of the December 11, 2006 x-ray (EX 5); and, the readings by Drs Wiot and Meyer of the December 21, 2006 x-ray (EX 8).[5] All of the negative interpretations were rendered by B-readers. Furthermore, Drs. Willis, Wiot, and Meyer are dual-qualified B-readers and Board-certified radiologists.

In summary, a slight majority of the substantive interpretations are negative for pneumoconiosis, including those by similarly well-qualified B-readers and/or Board-certified radiologists. Furthermore, while most of the x-rays have been interpreted as both positive and negative for pneumoconiosis, the December 11, 2006 x-ray has only been read as negative for pneumoconiosis. Thus, a slim preponderance of the x-ray evidence is negative for

[3] Claimant has no incentive to inflate his smoking history, particularly to a physician treating him for a stroke. Moreover, Claimant's apparent failure to tell some of the physicians that he had smoked cigarettes "irregularly" when he was young, may be attributable to memory problems associated with his stroke (TR 19).

[4] The record also contains Dr. Gaziano's rereading of the October 10, 2005 x-ray for quality purposes only. Dr. Gaziano, who is a B-reader, reported the film quality as "1" (*i.e.*, Good). (DX 11).

[5] Section 718.102(b) expressly states that a "0/1" classification "does not constitute evidence of pneumoconiosis."

pneumoconiosis. At best, the x-ray evidence neither precludes nor establishes the presence of pneumoconiosis, based upon the multiple positive and negative interpretations by various B-readers and/or Board-certified radiologists. In any event, Claimant has failed to meet his burden of establishing the presence of pneumoconiosis by a preponderance of the x-ray evidence.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains pulmonary function studies, dated October 10, 2005 (DX May 10, 2006 (EX 2), December 11, 2006 (EX 5), and December 21, 2006 (CX 1), respectively. All of the studies were conducted both before and after bronchodilator.

Of the four pre-bronchodilator tests, only the December 11, 2006 test is qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix B. Moreover, none of the post-bronchodilator tests are qualifying under the applicable criteria.

Since the clear majority of the pulmonary function studies are not qualifying, I find that the pulmonary function evidence does not establish a total (pulmonary or respiratory) disability. Furthermore, the fluctuation and improvement in some of the test results are inconsistent with the progressive and irreversible nature of pneumoconiosis.[6]

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

The record includes arterial blood gas studies, dated October 10, 2005 (DX 10), May 10, 2006 (EX 2), December 11, 2006 (EX 5), and December 21, 2006 (CX 1), respectively. None of the arterial blood gases (resting or exercise) are qualifying under the applicable criteria set forth in 20 C.F.R. Part 718, Appendix C. Accordingly, I find that the arterial blood gas study evidence does not establish a total (pulmonary or respiratory) disability.

[6] For example, Dr. Crisalli reported "significant post-bronchodilator improvement" on the pulmonary function test, dated December 11, 2006 (EX 5). Moreover, the results obtained on the December 21, 2006 pulmonary function studies were higher than those reported on the December 11, 2006 test (*Compare* CX 4; EX 5).

D. Physicians' Opinions[7]

The medical opinion evidence consists of CT scan interpretations (EX 4; CX 3), records from Dr. Reahl (EX 3), and the opinions of Drs. Rasmussen (DX 10), Zaldivar (EX 2, 6), Crisalli (EX 5, 7), and Gaziano (CX 1, 5).

Dr. Jerome F. Wiot, a B-reader and Board-certified radiologist, issued a report, dated December 15, 2006, in which he reviewed a CT scan of the chest, dated February 27, 2001 (EX 4). Dr. Wiot stated, in pertinent part:

> There is no evidence of coal worker's pneumoconiosis. The lung fields are clear. The CT is within normal limits.
>
> In summary, there is no evidence of coal worker's pneumoconiosis by CT.
>
> CT is medically acceptable for evaluation of pulmonary problems. CT is beneficial in confirming or denying the presence of simple coal worker's pneumoconiosis, and can be beneficial in recognizing complicated coal worker's pneumoconiosis when it is not evident on the routine chest xrays (sic).

(EX 4).

Dr. Edward Aycoth, a B-reader and Board-certified radiologist, reread the February 27, 2001 chest CT scan on or about February 8, 2007 (CX 3). Under "Clinical History," Dr. Aycoth set forth an inflated coal mine employment history of 26 years in the coal mines, and understated the Claimant's smoking history as only ½ pack per day from 1970 to 1992. However, Dr. Aycoth did not expressly relate the stated clinical history to his findings on the CT scan. Dr. Aycoth stated, in pertinent part:

> There are scattered rounded and irregular density opacities measuring up to 3 millimeters in diameter throughout both lungs. There is calcification of the hilar nodes and small bullae in both apices.
>
> IMPRESSION:
>
> Pneumoconiosis category ½, q/t.
>
> Thickening of minor fissure (pi).
>
> Eggshell calcification of hilar nodes (es).

[7] Medical reports and/or physicians' testimony which refer to documents not in evidence are deemed to have been redacted. Unless I make a specific finding herein that the redacted data is critical to a physician's ultimate opinion, the redaction of objectionable information will not materially affect the weight I accord such opinion. *See, Harris v. Old Ben Coal Co.*, 23 BLR 1-98 (Jan. 27, 2006); *see also, Webber v. Peabody Coal Co.*, 23 BLR 1-123 (Jan. 27, 2006)(en banc).

Bullae (bu).

(CX 3).

The medical records of Dr. Harry L. Reahl primarily involve neurological reports, dated October 19, 2000 through October 20, 2005 (EX 3). The records confirm that Claimant suffered a cerebrovascular accident in 1992, with left hemiparisis. The most recent report, dated October 20, 2005, sets forth the following "Objective" and "Assessment:"

> **OBJECTIVE:**
> [Claimant] is awake and alert, speech is fluent and appropriate, affect is broad. CNII-XII are significant for a left facial droop, decreased nasial (sic) labial fold. Motor strength is significant for minimal long tract weakness on the left, and holding the left arm in a slightly flexed posture. Coordination intact to finger to nose on the right, and ok on the left.
>
> **ASSESSMENT:**
> Cerebrovascular Disease (blood flow problems in the brain) #437.9.
> Cerebral Infarction #434.91 Stable with left upper hemiparesis
> Right Internal Carotid Artery 50 – 60%
> Left Internal Carotid Artery Very mild stenosis < 30%

(EX 3). The above-referred records are not directly relevant to the issues of coal worker's pneumoconiosis and/or total (pulmonary or respiratory) disability.. However, as stated above, they raise questions regarding Claimant's cigarette smoking history. For example, a report, dated August 7, 2001, signed by Dr. Hazem Ashbab, states under "Social History" – "No current smoking." (EX 3, p. 11). However, in reports, dated May 9, 2001 and April 15, 2002, respectively, Dr. Reahl stated: "TOBACCO: 1 ppd" (EX 3, pp. 6-7, 18).

Dr. Donald L. Rasmussen is a B-reader who is Board-certified in Internal Medicine and Forensic Medicine. Although Dr. Rasmussen is not Board-certified in Pulmonary Medicine, his curriculum vitae establishes that he has extensive experience in that field. Moreover, Dr. Rasmussen has testified on several occasions regarding coal worker's pneumoconiosis before subcommittees of the U.S. Senate and House of Representatives, and before the West Virginia Legislature (DX 10). Accordingly, I find that Dr. Rasmussen's qualifications are comparable to physicians who are Board-certified pulmonary specialists.

Dr. Rasmussen examined Claimant on October 10, 2005 (DX 10). On a U.S. Department of Labor form, dated October 20, 2005, Dr. Rasmussen set forth Claimant's employment, family, medical, and social histories (DX 10, Secs. B & C). Furthermore, Dr. Rasmussen reported Claimant's complaints of sputum, wheezing, dyspnea, and cough (DX 10, Sec. D1). However, on examination of the thorax and lungs, Dr. Rasmussen reported "normal" findings, with no rales, rhonchi, or wheezes (DX 10, Sec. D4). Dr. Rasmussen also conducted various clinical tests on October 10, 2005. On the form report, Dr. Rasmussen summarized the test results as follows:

Chest X-ray:	Pneumoconiosis s/s 1/1 all lung zones.
Vent Study (PFS)	Moderate, slightly reversible obstructive ventilatory impairment.
Arterial Blood Gas	Minimal impairment in oxygen transfer during very light exercise.
Other:	SBDLCO markedly reduced.

(DX 10, Sec. D5).

Under the Cardiopulmonary Diagnosis section of the form report, Dr. Rasmussen set forth the following diagnoses and underlying rationale: "Occupational Pneumoconiosis – 15 years of coal mine employment and highway construction and x-ray evidence of pneumoconiosis. COPD/Emphysema – Chronic productive cough, airway obstruction and reduced SBDLCO" (DX 10, Sec. D6). When asked the etiology of the cardiopulmonary diagnoses and provide his rationale, Dr. Rasmussen stated: " Occupational Pneumoconiosis - Coal mine dust exposure, exposure to silica and other exposures. COPD/Emphysema – Coal mine dust exposure, and other road construction exposures and cigarette smoking." (DX 10, Sec. D7). In response to the form question regarding the severity of Claimant's impairment and the extent to which the impairment prevents him from performing his last usual coal mine job, Dr. Rasmussen stated: "Overall, these studies indicate at least moderate loss of lung function. The patient does not retain the pulmonary capacity to perform his last regular coal mine job." (DX 10, Sec. D8a). When asked the extent to which each of the cardiopulmonary diagnoses contributes to this impairment, Dr. Rasmussen stated:

> The patient has a significant history of exposure to coal mine dust as well as other occupational exposures including especially silica. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude the patient has occupational pneumoconiosis, i.e., silicosis, which arose as a consequence of both of (sic) his coal mine dust exposure and his other dusty occupations.
>
> The two known causes of [Claimant's] impaired function are his cigarette smoking and his coal mine dust exposure. Both contribute since both cause similar lung tissue destruction.
>
> The patient's coal mine dust exposure is a significant contributing factor to his impaired function. The patient has clinical pneumoconiosis, which contributes significantly to his loss of lung function.

(DX 10, Sec. 8b). In an accompanying typewritten report, Dr. Rasmussen essentially repeated the same data and conclusions as was set forth in the U.S. Department of Labor report (DX 10).

Dr. George L. Zaldivar is a B-reader, who is Board-certified in Pulmonary Disease, Internal Medicine, Sleep Disorder, and Critical Care Medicine. Dr. Zaldivar examined Claimant on July 13, 2005. In a "History & Physical Examination" report on that date (EX 2), Dr. Zaldivar set forth Claimant's chief complaints of shortness of breath, history of present illness,

past medical history, work history, personal and social history, personal illnesses, and, review of systems. Under "Past Medical History," Dr. Zaldivar reported a cigarette smoking history of "about ten cigarettes per day" (*i.e.*, ½ pack) beginning in 1959 or 1960 and ending in 1992. Under "Work History," Dr. Zaldivar reported an 18-year coal mine employment history ending in 1992, when he quit the mines because of a stroke. Although Claimant's last coal mine job as a foreman at the strip mines entailed supervisory duties, it also involved considerable walking and lifting items weighing about 100 pounds. Claimant reportedly stated that if the items were too heavy, he had someone with him. In addition, Dr. Zaldivar set forth his findings on physical examination. Dr. Zaldivar stated, in pertinent part: "LUNGS: There are a few end inspiratory crackles present at the lung bases posteriorly." In summary, Dr. Zaldivar stated, in pertinent part:

> **IMPRESSION:**
>
> 1. History of cerebrovascular accident with paralysis of the left arm and weakness of the left leg.
>
> 2. Normal examination of the lungs.[8]
>
> 3. Past history of smoking.
>
> 4. Past history of mine work.

(EX 2).

In a supplemental report, dated June 1, 2006, Dr. Zaldivar analyzed the history and physical examination which he had reported, as well as the laboratory data which he obtained. Moreover, Dr. Zaldivar also reviewed other records provided by Employer's representative. In summary, Dr. Zaldivar stated:

> **FINDINGS**
>
> My own findings are as follows:
>
> 1. Summary of this history and physical examination as listed under "Impression."
>
> 2. Moderate irreversible airway obstruction.
>
> 3. No air trapping by lung volumes.
>
> 4. Mild diffusion impairment.

[8] As stated above, Dr. Zaldivar, in fact, reported some abnormalities (*i.e.*, a few end inspiratory crackles at the lung bases). Therefore, the examination of the lungs was not entirely "normal." However, in the absence of more extensive crackles, or other reported abnormalities on examination, such as rales, rhonchi, or wheezes, Dr. Zaldivar apparently considered the overall lung examination to be essentially normal.

5. Abnormal cardiopulmonary stress test. Electrocardiogram was abnormal, perhaps due to a previous pericarditis. The blood gases were normal at rest and with a small amount of exercise that he performed at 7.5 cc/kg/min.

6. No radiographic evidence of pneumoconiosis. There is a suspicion of a bullae in the right upper lobe, but this is not definitive and therefore I did not mention it in my report.

(EX 2). Dr. Zaldivar set forth a further discussion of Claimant's x-ray evidence, including an acknowledgement that he "found a hint of some nodules in the left upper and left mid zone." In addition, Dr. Zaldivar cited medical literature which related the amount of dust retention, as shown by the number of macules, in determining whether damage was caused to the lungs by coal dust, or whether it was due to other potent causes, such as smoking. In conclusion, Dr. Zaldivar stated:

COMMENTS:

Taking all of this information into consideration, my answers to your (Employer counsel's) questions are as follows:

1. There is not sufficient medical evidence to diagnose coal workers' pneumoconiosis nor any dust disease of the lungs. This opinion comprises both a strict medical diagnosis of pneumoconiosis and the brother diagnosis of pneumoconiosis.

2. There is a pulmonary impairment present. The pulmonary impairment is the result of his smoking habit which has been lifelong and sufficient to produce emphysema. It should be noted that his emphysema was only mild as noted by the normal resting and exercise blood gases.

3. Strictly from the pulmonary standpoint, [Claimant] is not disabled. He retains the pulmonary capacity to perform his usual coal mining work or work requiring similar exertion.

4. [Claimant] is disabled as a whole man however, because he had a cerebrovascular accident which in fact forced him to quit the coal mines. The cerebrovascular accident not only affected his motor function, but also affected his thinking according to the statements made by his wife. Such cerebrovascular accident and its effects are not the consequence of his occupation as a coal miner.

(EX 2). Dr. Zaldivar reiterated the above-stated opinion in his deposition testimony on February 26, 2007 (EX 6, pp. 11-12, 19). However, Dr. Zaldivar acknowledged that, if Claimant does not take bronchodilators, he would only be able to perform his last coal mine employment on his "good days." (EX 6, p. 17). In any event, Dr. Zaldivar testified that

Claimant's pulmonary impairment is not attributable to coal dust exposure, while noting the variable clinical results, and the improvement shown on the pulmonary function studies obtained by Dr. Crisalli after bronchodilator (EX 6, pp. 17-19).

Dr. Robert J. Crisalli, who is Board-certified in Internal Medicine and Pulmonary Disease, examined Claimant on December 11, 2006 (EX 5). Dr. Crisalli completed a "History and Physical" report, and issued a supplemental report, dated February 6, 2007 (EX 5). Dr. Crisalli stated that he had arrived at the following diagnoses and conclusions:

1. No evidence of occupational pneumoconiosis.
2. Chronic obstructive pulmonary disease.
3. Anemia.
4. Cerebral vascular disease.

(EX 5). Dr. Crisalli reported a coal mine employment history of 18 years ending on September 21, 1992, when Claimant had a stroke. In the History and Physical" report, Dr. Crisalli described Claimant's last usual coal mine job as a foreman at a strip mine job. Although many of his duties involved directing various operations, it also entailed standing six to eight hours a day, and lifting up to 100 pounds of material two or three times per day, and carrying it a distance of 20 to 30 feet. Dr. Crisalli also reported that Claimant "smoked cigarettes for 10 to 15 years at less than one pack per day and stopped in November of 1992." Furthermore, Dr. Crisalli provided a detailed summary of his own clinical findings, and also discussed some other limited data. Based upon the foregoing, Dr. Crisalli stated:

> In summary, there is not sufficient evidence to justify a diagnosis of coal workers pneumoconiosis or any chronic dust induced disease of the lung in [Claimant's] case. There is no evidence of either medical or legal pneumoconiosis. [Claimant] has a moderate degree of respiratory impairment but this improves to only a mild degree after bronchodilators raising the possibility that he has asthma as well as chronic obstructive pulmonary disease. None of the impairment related to chronic obstructive pulmonary disease or, possibly to asthma, can be attributed to either medical or legal pneumoconiosis. [Claimant] has a significant smoking history and the pattern of the disease is consistent with the smoking history. Obstruction related to coal workers pneumoconiosis should not respond to bronchodilators.
>
> Based on [Claimant's] response to the bronchodilators on the pulmonary functions and based on the fact that he is not on any respiratory medications at home, I believe that adequate bronchodilator therapy would render [Claimant] able to perform his previous coal mine job or a job requiring similar effort outside the mines from the standpoint of his pulmonary functional status. [Claimant] may be disabled on the basis of his previous stroke and the residual but his marked response to bronchodilators tells me he is not disabled on the basis of his pulmonary functional status.

(EX 5). In his deposition testimony, dated February 28, 2007, Dr. Crisalli discussed his own findings and the clinical data obtained by other physicians, such as Drs. Rasmussen and Zaldivar.

Based upon the foregoing, Dr. Crisalli reiterated that Claimant does not suffer from coal worker's pneumoconiosis, as evidenced by the variable nature of Claimant's ventilatory impairment. Furthermore, Dr. Crisalli stated that Claimant may not be precluded from performing his last coal mine job from a pulmonary standpoint, especially if he received adequate bronchodilator therapy. In the absence of such treatment, Dr. Crisalli stated that there would be days that he could do his work, and other days that he could not (EX 7, pp. 20-25).

Dr. Dominic J. Gaziano, a B-reader who is Board-certified in Internal Medicine and Chest Disease, examined Claimant on December 21, 2006 (CX 1). Dr. Gaziano obtained extensive information regarding Claimant's employment history, which is attached to the report, dated January 3, 2007 (CX 1). Dr. Gaziano set forth an occupational history, which he estimated as "about 15-18 years" during the period from 1966 to 1992. Dr. Gaziano noted that, in addition to working as a surface miner, Claimant had worked for about 11 years in highway construction. Dr. Gaziano also reported a smoking history of ½ pack per day from 1976 to November 1992; past medical history; and, review of systems. On physical examination, Dr. Gaziano reported, in pertinent part: "Chest was symmetrical. Lungs were clear to auscultation and percussion." Dr. Gaziano also administered various clinical tests, including a chest x-ray, pulmonary function tests, and arterial blood gas. He interpreted the chest x-ray as positive for (1/1) pneumoconiosis; the pulmonary function study "showed moderate irreversible obstructive ventilatory impairment;" and, the resting arterial blood gas was "normal." In summary, Dr. Gaziano stated:

> It is my opinion, to a reasonable degree of medical certainty, that [Claimant] has coal workers' pneumoconiosis with a moderate degree of pulmonary functional impairment.
>
> This report relates only to the diagnosis of an occupational lung disease and is not intended to serve as a comprehensive evaluation of health problems. If there are any questions concerning this report, please feel free to contact me.

(CX 1).

Dr. Gaziano issued a cursory supplemental letter, dated January 29, 2007 (CX 5). The full text is as follows:

> In response to your [Claimant counsel's] letter of 01/22/2007 concerning [Claimant's] work capacity, there is a moderate breathing impairment that would limit him to medium work. The job description that you provided indicated that he would have to lift 70-100# on a regular basis which would put him in a heavy work designation. I do not believe [Claimant] could perform that level of work.
>
> If there are any questions concerning this please feel free to contact me.

(CX 5).[9]

[9] Attached thereto is a document entitled "Appendix A Physical Demands," with a handwritten notation – "Dept of Labor Manual." The classification "Heavy Work" has been circled. The description thereunder is as follows: "Lifting 100 lbs. Maximum with frequent lifting and/or carrying of objects weighing up to 50 lbs." (CX 5).

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, a slight majority of the x-ray interpretations, including those by B-readers and/or Board-certified radiologists, are negative for pneumoconiosis. Accordingly, I find that a slim preponderance of the x-ray evidence is negative for pneumoconiosis. At best, the conflicting x-ray interpretations by similarly well-qualified B-readers and/or Board-certified radiologist, would render the x-ray evidence inconclusive. In any event, Claimant has not met his burden of establishing the presence of pneumoconiosis by a preponderance of the x-ray evidence. Therefore, Claimant has not established the presence of pneumoconiosis under §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.202(a)(1) and (2).

As stated above, the medical opinion evidence consists of CT scan interpretations (EX 4; CX 3), records from Dr. Reahl (EX 3), and the opinions of Drs. Rasmussen (DX 10), Zaldivar (EX 2, 6), Crisalli (EX 5, 7), and Gaziano (CX 1, 5).

The CT scan evidence is in equipoise, since similarly well-qualified B-readers and Board-certified radiologists (*i.e.,* Drs. Wiot and Aycoth) had conflicting opinions regarding whether pneumoconiosis was present. Furthermore, the records from Dr. Reahl do not directly address the contested issues in this case. Accordingly, the crux of this case rests on the relative weight accorded to the medical opinions of Drs. Rasmussen, Zaldivar, Crisalli, and Gaziano, respectively.

As fact-finder, I have conducted a qualitative assessment of the medical opinion evidence by analyzing the credibility of each medical opinion considered as a whole, in light of that physician's credentials, documentation, and reasoning. As stated above, Drs. Zaldivar, Crisalli, and Gaziano are all Board-certified pulmonary specialists, while Dr. Rasmussen lacks such Board-certification. However, in view of Dr. Rasmussen's considerable pulmonary experience, I

find that his credentials are comparable to those of Board-certified pulmonary specialists. Therefore, the relative qualifications of Drs. Rasmussen, Zaldivar, Crisalli, and Gaziano are not determinative. However, I find that the opinions of Drs. Zaldivar and Crisalli regarding the pneumoconiosis issue outweigh those of Drs. Rasmussen and Gaziano, because the opinions of the former are better reasoned and documented.

In making this determination, I note that Drs. Rasmussen and Gaziano relied, in part, upon questionable positive x-ray interpretations. Furthermore, their opinions were based upon limited medical data associated with their own examinations of the Claimant.
In contrast, Drs. Zaldivar and Crisalli not only considered the medical data which they obtained, but also clinical tests administered by other physicians. Although Dr. Zaldivar found a "moderate irreversible airway obstruction" on the pulmonary function studies which he administered on May 10, 2006 (EX 2), he testified that the results obtained by Dr. Rasmussen on October 10, 2005 were worse. In addition, Dr. Zaldivar cited the results later obtained by Dr. Crisalli on December 11, 2006, which showed post-bronchodilator improvement. Dr. Zaldivar testified that this variability and improvement is inconsistent with the irreversible nature of pneumoconiosis (EX 6, pp. 12-15). Furthermore, Dr. Crisalli reported that Claimant suffered from a moderate degree of impairment, which improved to only a mild degree of impairment after bronchodilators. Moreover, Dr. Crisalli also considered other physicians' clinical test results in his deposition testimony, as well as other data, in finding that Claimant did not establish clinical or legal pneumoconiosis (EX 5, 7). In view of the foregoing, I find that Claimant has failed to establish pneumoconiosis under §718.202(a)(4), or by any other means.

I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from pneumoconiosis. Since the weight of the x-ray evidence and medical opinion evidence fails to establish the presence of pneumoconiosis, I find that pneumoconiosis has not been established under 20 C.F.R. §718.202(a). *See, Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F. 3d 22 (3d Cir. 1997).

Total Disability Due to Pneumoconiosis

As outlined above, the medical opinion evidence is conflicting and/or ambiguous regarding the presence or absence of a totally disabling pulmonary or respiratory impairment. The evidence suggests that, if Claimant were properly treated with bronchodilators, he may be able to perform his last usual coal mine work from a pulmonary standpoint; but, in the absence of such treatment, Claimant would only be able to work on his "good days." However, as stated above, Claimant has not established (clinical or legal) pneumoconiosis. Therefore, Claimant has clearly failed to establish total disability *due to pneumoconiosis* under §718.204(c).

Conclusion

Having considered the relevant evidence, I find that Claimant has not established the presence of (clinical or legal) pneumoconiosis and/or total disability due to pneumoconiosis. Accordingly, Claimant is not eligible for benefits under the Act and regulations.

ORDER

It is ordered that the claim of L.L.R. for benefits under the Black Lung Benefits Act is hereby **DENIED.**

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).

E-FOIA Notice: Under e-FOIA, final agency decisions are required to be made available via telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. § 552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). It is the policy of the Department of Labor to avoid use of the Claimant's name in case-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an

appeal is taken to the Benefits Review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.